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An exploration of the implementation of open disclosure of adverse events in the UK: a scoping review and qualitative exploration

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Plain English summary

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Plain English summary

Open disclosure of adverse events, in terms of health care, refers to the practice of telling people if they have been harmed by a mistake when receiving care. In 2009, the National Patient Safety Agency relaunched its Being Open framework to support open disclosure in the UK. We explored how this guidance has been received, combining the literature on open disclosure with findings from interviews. We reviewed the international literature on open disclosure since 1980, identifying over 600 papers, predominantly from the last 12 years. Simultaneously, we conducted 86 interviews with respondents from a range of stakeholder groups, including policy-makers, health professionals, NHS managers, representatives from professional bodies and patients. Evidence from both the literature and the interviews showed that the principle of truthfulness was widely supported but not always upheld. Many factors seem to create uncertainties over what should be disclosed, by whom, when and how. Being honest and open about mistakes is theoretically supported but seems considerably more difficult in practice. In conclusion, the evidence suggests that open disclosure should be a process and not a one-off event as it is often described. Open disclosure should be a conversation whereby information is shared and the patient is both listened to and responded to. The key message from this report seems to be that while open disclosure is widely regarded as the right thing to do, creating a culture of openness remains challenging, yet necessary, if patients are to be involved effectively in all aspects of their care.

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